[Your Name]
[Your Address]
[Your City, State, Zip Code]
[Your Phone Number]
[Your Email Address]

[Date]

[Name of Debt Collection Agency or Billing Department]
[Address]
[City, State, Zip Code]

RE: Notice of Disputed Medical Debt and Request for Insurance Adjustment Verification

Account Number: [Account Number]
Patient Name: [Patient Name]
Date of Service: [Date of Service]
Total Amount Disputed: $[Amount]

To Whom It May Concern,

I am writing to formally dispute the debt associated with the account referenced above. I am requesting a full verification of this debt, specifically regarding the insurance adjustments and payments applied to this balance.

I believe this debt is inaccurate because it does not reflect the correct contractual adjustments required by my insurance provider, [Insurance Company Name]. I am requesting that you provide the following documentation:

- An itemized statement of all charges.
- A copy of the Explanation of Benefits (EOB) sent to you by my insurance provider for these specific services.
- Verification that the balance reflects the "allowed amount" as determined by my insurance policy.
- Confirmation that all secondary insurance, if applicable, has been billed and processed.

Please note that under the Fair Debt Collection Practices Act (FDCPA) and relevant state laws, you must cease collection efforts on this account until you have provided the requested verification and evidence that the amount listed is correct after all insurance adjustments.

I expect a response within 30 days of your receipt of this letter. Thank you for your immediate attention to this matter.

Sincerely,

[Your Signature]

[Your Printed Name]